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ABSTRACT

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QUALITY OF LIFE IMPACT ON MENTAL HEALTH NEEDS*

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Recent research indicates that basic indicators of quality of life have some consistent associations with mental health needs.

Factors such as socioeconomic status, proportion of a population in poverty, unemployment and underemployment rates, family instability and family life cycle have persistent associations with social and economic stress and mental health needs. By considering these factors in aggregate, areas of relatively low and high need can be identified.

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INTRODUCTION

Quality of life has always been a concern of individuals and families. The degree to which societies have been explicitly concerned with the quality of life of their citizens and particularly with a basic minimal level of quality of life for all citizens is a more recent historical phenomenon.

Quality of life is a complex concept which can only be assessed and compared within a specific social and cultural context. This discussion will focus on quality of life effects on mental health in the context of the social structure and culture of the United States.

Demographic characteristics are used to define various degrees of quality of life or states of well being and their relationship to mental illness. The demographic data utilized is that included in the Mental Health Demographic Profile System (MHDPS) of the National Institute of Mental Health. The MHDPS provides information from the 1970 census, including specific social and economic variables for each community mental health catchment area* in the United States and also for each census tract, county, minor civil division (in some states) and state in the nation. These catchment area profiles contain extensive data in six broad social areas: socioeconomic status, ethnic composition, household composition and family structure, style of life, condition of housing and community stability. In addition, the system includes data on the distribution of the population of each area by age, sex, color, and marital status. Underlying the development of this system is the assumption that certain characteristics of a population (poverty, overcrowding, low occupational status, and so forth) are associated with high risk in terms of need for mental health and other social and health services. It is expected that MHDPS can help identify communities with greater needs.

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*Catchments are Mental Health Service areas covering all of the U.S. Some 1499 catchments were defined by the states under general NIMH guidelines such as about 75,000 to 200,000 population base.

THE USE OF DEMOGRAPHIC AND EPIDEMIOLOGIC DATA TO INDICATE MENTAL ILLNESS INCIDENCE AND NEED FOR SERVICES

The first estimates of the prevalence of mental disorders were based upon rates calculated from surveys of persons who were psychiatric patients. (For examples, see Faris and Dunham, 1939; and Hollingshead and Redlich, 1958.) Not surprisingly, such studies yielded rather low prevalence rates. However, if one is to accurately estimate the need for mental health services in an area, it is necessary to go beyond the known clinical populations. As Henisz and associates (1974: p. 51) point out: "To gain some estimate of the need for service in a particular area, it is necessary to study the prevalence of treated, untreated or even unrecognized disorder within the community ... a mental health survey provides the most accurate information of this type."

Of necessity, such surveys base their estimates of need for mental health services on symptomatology. Two of the most influential surveys were the Mid-town Manhattan Study (Srole, et. al. 1962) and the Stirling County, Nova Scotia Survey (Leighton, et. al., 1963). The first was an urban sample of 1660 men and women between the ages of 20 and 59. The second was a rural sample from both socially integrated and socially disintegrated communities.

> While the two studies differed somewhat on how they defined a psychiatric case, their estimates of the extent of psychiatric impairment in the general population were staggering. In the Stirling County Study, it was concluded that at least half of the adults...are currently suffering from some psychiatric disorder defined in the APA Diagnostic and Statistical Manual.... In the Mid-town Manhattan Study, using a more limited definition of psychiatric impairment, nearly one quarter of the sample was judged to be significantly psychiatrically impaired.... Their startling assertions as to the high prevalence of psychopathology in the general population undoubtedly served as a significant impetus for the development of increased federal resources to deal with problems of mental disorder. (Bloom, 1975, pp.36-37)

Mental health surveys of the general population differ from the psychiatric patient surveys in two major respects. First, the survey does have the opportunity to reveal a number of persons with mental disorders who have not sought treatment. The community surveys also have the drawback that the symptoms approach may well screen in numbers of persons who are not mentally ill. Therefore, it is not surprising that in examining twenty-five studies of untreated cases of psychological disorders the Dohrenwends (1969) found prevalence rates reported in studies carried out after 1950 to be more than seven times those reported in 1950 or earlier. These differences reflect differences in the criteria used to distinguish mental health from mental illness.

A recent NIMH report indicates that facts on the frequency of occurrence of mental disorders in the general population is one of our most serious unmet data needs. "The available information is largely restricted to people who have been treated at a psychiatric facility. However, many people are not treated there, and many others are not treated at all. Surveys made over the last three decades show, at one extreme, eight persons per 1,000 known to be under psychiatric care and, at the other extreme, 240 persons seriously impaired out of every 1,000 persons (aged 20-59 years) not in institutions. Practical and reliable case-finding techniques do not exist." (Segal and Boomer, 1975, p. 69)

In addition to the Mid-town Manhattan Study, Rosen (1974) uses the 11% prevalence estimate from Pasamanick's (1961) Baltimore Study and the 7% estimate from Roth and Luton (1943) from a rural Tennessee county. For the U. S. as a whole in 1971, combined admission rates to mental hospitals, out-patient clinics, and inpatient services of general hospitals was over 1% of the total population; on the basis of these figures, Rosen (1974) uses a model which assumes "a minimum overall 2% level of illness...without attempting to apply higher percents to high risk groups." If we continue to use a strategy of uniform rates of mental illness for areas, then the only variable we would need to consider when estimating level of mental instability in an area would be its

total population. However, there is very strong consensus in the literature that there are high risk groups in the total population (Redick, et. al., 1971). Factors which have been suggested as useful in identifying catchment areas as high risk include socioeconomic status, ethnic composition, age, sex, family life cycle, crowding, mobility, and other related variables. These are discussed below. However, how much each of these factors increases or decreases risk and under what circumstances, is still an unanswered question.

The intent in the discussion below is to indicate from the review of literature by members of the Research Team in Applied Social Sciences and that of others (such as Warheit, et. al., Dohrenwend, Sorkin, et. al., and Froland) the relationship expected between the variables and the level of mental illness. These expectations are consistent with research results and theory. They are based on research knowledge about human behavior and the effects of types and qualities of social relations and conditions on behavior.

This discussion also includes indications of the need for more definitive research. Where research results differ, an attempt has been made to assess whether methodology and/or research settings and populations could account for the differences. Generally, research which has used multiple variable analyses and control variable designs has been given more weight than those not using such controls and designs.

Age, Sex and Family Life Cycle

Age and sex are demographic variables which have an influence on behavior and the incidence of mental illness. The relationships occur because of biological, social and cultural influences. Males and females are socialized differently by sex. The varying expectations and norms applicable to each sex require different patterns of behavior and place different stresses on females and males. Such differences are associated with different types of illness, perhaps in part because social and cultural expectations for males and females also influence diagnosis.

Overall the lowest rates of mental illness are among younger persons while the higher rates of symptoms and illness occur for the aged. Various types of illness have both age and sex correlates. For example, organic brain syndromes are said tobe clearly disorders of the aged (Warheit, et. al., 1968-74; Froland, 1975). On the other hand, schizophrenia rates were found highest for males in the mid-twenties and females in the mid-thirties. In sum, mental illness rates are reported lowest for the young, varied in the mid-years and higher among the aged (Froland, 1975; Warheit, et. al., 1968-74; Dohrenwend and Dohrenwend, 1969).

Generally, women have higher rates of mental illness. In terms of specific illnesses, men have higher rates for schizophrenia while women exhibit higher rates for depressive and psychoneurotic disorders. Higher mortality rates and poorer treatment success is recorded for males (Froland, 1975; Warheit, et. al., 1968-74; and Dohrenwend, 1969).

Currently there seem to be no definitive rates specified, by age-sex categories, either for various disorders or for total incidence. It is recognized that certain roles, specifically family life cycle roles, are associated with age and sex. Family life cycle is a significant dimension because it is more precise than age or sex in denoting status-role designations and changes (entering or graduating from school, getting married, having an infant, toddler or adolescent child, buying a house, living alone). Moreover, not only is most of the information provided by the age and sex characteristics accounted for by family life cycle properly conceptualized, but the family life cycle dimension has the added advantage that it emphasizes and forces us to cope with the fact that sets of status roles are linked together -- parents have children and children have parents. One is not simply dealing with groupings of persons by age and sex. For example, when considering the problem of special target populations such as young children or adolescents, it is important to simultaneously consider the marital, parental and work problems of their parents.

The dimension, 'family life cycle,' plays an important, if not crucial, role in explaining and predicting behavior of both males and females at different

ages. Changing life styles and role patterns make it difficult to describe a "typical family" but do not alter the fact that roles and obligations and accompanying social and psychological pressures can be expected to change as a person's stage in the family life cycle changes. For example, during the earlier stages of the family life cycle, couples are learning to be husbands and wives, balancing sexual and affiliation needs. With the arrival of a child, new role responsibilities must be assumed and previous responsibilities adjusted. Wives may abandon or temporarily reduce their participation in the labor force in order to provide child care. Husbands then assume major responsibility for wage-earning.

In contrast, the late childrearing period (presence of an adolescent person in the household) is associated with the intensificiation of control-independence problems of children and their parents. Among adolescents, one can anticipate a resurgence of nurturant (affiliation) needs (Veroff and Feld, 1970). Such needs could be met through a continuance of clear-cut and accepted parental and child roles established during the middle childrearing period. However, since adolescent persons are demanding greater independence and autonomy and are encouraged to be more self-reliant, the meeting of these affiliation needs through the maintenance of strict control by parents is both more difficult and, in some ways, inappropriate. To be successful in the late childrearing period, parents must modify their perceptions of the parent role, particularly with respect to the control of children. Further, for women who have focused primarily on the mother role, the late childrearing period is a critical time when appropriate role alternatives must be developed. Similarly, husbands, who have focused primarily on their work roles may at this time be aware of career limitations and searching for satisfactory supplementary roles. The adjustment of this stage may be less problematic for men and women who have been developing supplementary roles over the years. In this regard, it is noteworthy that more than 50% of women with children 6-17 participate in the labor force (Hoffman and Nye, 1975, p. 22). Further, "there is no suppor t for the thesis that the mental health of employed mothers is worse than that of

housewives. In fact, slight differences favored employed women " (Hoffman and Nye, 1975, p. 213).

Problems associated with family life cycle are also believed to be linked to social class. The following paragraph from Veroff and Feld illustrates the interaction between these two dimensions:

> The grade-school-educated father seems to be most involved and satisfied when he has young children and most disturbed by his parental role when his children are adults; the high-school-educated father is most actively satisfied with children during middle childhood; there are trends to indicate that the college-educated father is most involved with his children when they are adolescents or adults (Veroff and Feld: p. 342).

We therefore suggest that research on the relationship of family life cycle with controls on age, sex, social class, etc. will prove to be very fruitful in the study of mental health and illness as well as other social problems.

One illustration of the use of family life cycle in interpreting the use of family doctors comes from research in a rural county of Maryland (Konan and Longest, 1976, pp. 22-23).

> This study shows that patterns of use of health services do vary for families at various stages of the family life cycle. Use of family doctors is highest during the early stage in which child-bearing and early childrearing takes place and lowest for late stage families with no children under 18 years.... The relationship between family life cycle stages and use of family doctors persists when income is controlled.

The authors conclude:

> As might be expected, family life cycle appears to reflect the differences in utilization based on age and sex which have been well documented in the literature. However, since the usual ages at which husbands and wives reach the several stages of the family life cycle have changed over time and may change in the future, the family life cycle concept provides a summary of family characteristics which may be useful in time series studies. It may prove helpful in health care planning to consider family life cycle along with other variables in developing social indicators to predict need for or

utilization of various health services...

> For those concerned with making policy and providing health care, coordination of services requires an ability to predict "demand" with some degree of accuracy. Usually this must be done without the benefits of extensive personal interviews, using data available from census and other surveys. To the extent that family life cycle adds to the predictive capacity of other variables it will facilitate health care planning. In addition, since health care personnel relate to families rather than individuals in providing certain kinds of care, a better understanding of the relationship between family characteristics and use of health services may suggest new approaches to encourage use of preventive care services.

Socioeconomic Status

The relationship of socioeconomic status to mental illness incidence rates has been affirmed in a number of recent reviews and research projects (Warheit, et. al., Bibliography 1968-1974; Froland, 1975). Historically, research has shown a persistent relationship between socioeconomic status and ability to function effectively socially and occupationally. In general, ability to cope in a wide range of situations increases in a statistical sense as level of socioeconomic status increases. Research on the effects of stressful events also finds that stressful events tend to be more detrimental and have more negative impact for low socioeconomic status persons than for those of higher socioeconomic levels (Dohrenwend and Dohrenwend, 1974). These latter findings support the general findings on the relationship between socioeconomic status and the incidence of mental illness and begin to answer some of the "why?" questions.

Socioeconomic status is generally indexed by the combination of income, occupational, and educational status. These variables are highly correlated with one another; when combined they tend to provide a reliable and valid measurement of socioeconomic status in U. S. society.

Service areas in most cases, will be composed of a wide range of socioeconomic level areas but the mix of moderate, low and high socioeconomic

status areas will vary widely from one area to another. Some areas may be composed primarily of high status persons, others of low, and so forth. The variations in mix could very readily affect need or incidence as well as resources and the utilization of resources. The mix effect of socioeconomic variables is one of the research problems which needs more definitive answers.

With respect to mental health, the general position is that low social rank, however measured, is consistently observed to be associated with serious mental disorder (psychopathology) (Bloom, 1975: 35; Dohrenwend and Dohrenwend, 1969: 148. Also see Froland, 1975 and Warheit, et. al., 1975). Bloom (1975: 40) summarizes this position as follows:

> Low socioeconomic level repeatedly has been shown to be associated with mental disorder. This association has been found in studies based on treated incidence, treated prevalence, and on community surveys of the general population and in studies based on ecological assessments of environments as well as on demographic assessments of patients contrasted with some type of nonpatient comparison group.

Generally, the above relationship holds within racial or ethnic populations and within specified residential areas, or central place or administrative regions (Dohrenwend and Dohrenwend, 1969). Several qualifications to the above relationship should be noted. First, neuroses tend to be concentrated in the middle and upper classes (Hollingshead and Redlich, 1958). Second, "manic depressive disorders, unlike the schizophrenias and personality disorders, most often occur in some class other than the lowest" (Warheit, et. al., 1974: 162). Third, "...socioeconomic differentials disappear in areas of small populations" (Kohn, 1970: 116).

Ethnic Composition

The proportions of black and ethnic populations are important factors which affect service delivery and incidence of mental illness. If there is segregation, discrimination, and/or language differences then one can expect the ethnic groups to have some problems with access to and utilization of services.

If high proportions of the ethnics are also in low socioeconomic status, the incidence of mental illness and need for services can also be expected to be relatively high. Persons of high need, low utilization, and low family resources who are not fully in community social interaction patterns typically have both short and long range problems. The long range prognosis without deliberate intervention is usually an increase in need among ethnic group members and an increase in the social problems and welfare budgets for the total community.

Research problems involved include: What are the varying consequences for the ethnic members of their being a small proportion versus nearly equal to or a majority in a particular area? There is some evidence that a very small black population in a predominantly white area or a very small white population in a predominantly black area will experience higher rates of mental illness (Klee, 1967). Additional questions might center around whether the types of illness will vary according to the ethnic composition of the community and with the length of time that the accompanying circumstances continue. The consequences may also vary by whether the community is rural, urban or suburban.

Household Composition

There are a number of household composition variables which relate directly to stress and the incidence of mental illness. Relevant for mental health are percent households with only one person, female headed households, particularly with children, and persons not living in families.

Percent of households with only one person, if high, can be an indication of higher incidence particularly if the rate of family breakup is high; since those persons who are single, divorced, widowed and separated generally have an incidence higher than those married (with the exception of single vs. married women) (Warheit, et. al., 1968-74; Dohrenwend, 1974; Froland, 1975; Pollack, 1975). On the other hand, large households of more than 6 persons, if combined with low incomes and other factors such as broken homes, can indicate greater incidence of mental illness both for the mother and the children.

Non-husband-wife Households

One-parent families, and particularly female-headed households with children have been characterized by a higher incidence of mental illness for both the female head and the children involved. This is generally believed to be related to a combination of increased stress and a lowering of social psychological and financial resources which usually accompanies one-parent attempts to cope with the roles and functions generally shared by both parents (Warheit, et. al., 1968-74; Dohrenwend and Dohrenwend, 1975; Sorkin, et. al., 1973; Froland, 1975; Pollack, 1975). In the female-headed households absent or inadequate fathers have been considered by many psychologists as a cause of personality problems in children, poor social adjustment, and juvenile delinquency (U. S. Department of Health, Education and Welfare, 1969; Bernard, 1966).

The absence of a parent may affect black and white children differently. Larry and Jane Hunt are cited in Behavior Today (1975) as suggesting:

> The white adolescents followed the pattern uncovered in earlier studies. Fatherless boys had poorer grades, lower educational aspirations, and fewer of them expected to marry. They also scored lower on the esteem and sex-role scales. This held true for all social classes, with the effect on self-esteem particularly strong among lower-class adolescents. Black adolescents were a different story. The fatherless boys scored slightly higher on all achievement and self-attitude categories than boys who had fathers. This was true for all social classes.

Hunt and Hunt suggest that this difference can be explained by the positions black and white fathers have in our society. "The white father is usually the breadwinner, a respected member of the family who serves as a positive model of achievement for his son. Many black fathers, hampered by discrimination and a lack of economic opportunity, can serve only as models of failure. Their sons are no worse off, and may be better off, if their fathers aren't around as examples of what a black adolescent can look forward to." (Hunt and Hunt, 1975).

Persons not in families

Persons living in group quarters, inmates of institutions and residents of nursing homes and mental hospitals, represent a mixed risk population. Those already under mental illness treatment are known cases; those in homes for the aged, prisons, etc., are known to have relatively high incidence rates too. Persons who live in rooming houses and other noninstitutional group quarters might be expected to have somewhat higher rates than those in families in the general population but less than those in various types of institutions.

Persons in households unrelated to the household heads and household heads who are primary individuals also have somewhat higher rates than those in the usual family units (Warheit, et. al., 1968-74; Froland, 1975).

This is most apparent for persons who live alone. Based primarily on ecological correlation, there is a positive association between severe mental disorder (excluding neuroses) and percent of persons living alone (Slem, 1975). The usual explanation for this relationship is that persons who do not live in family units are more apt to be social isolates and, accordingly, have higher levels of severe disability. Bloom (1975: 306) summarizes this position as follows:

> These findings, taken together, suggest that social isolation may be a stressor associated with psychiatric hospitalization. The social isolation hypothesis, first advanced by Faris and Dunham (1939) serves to link these diverse findings by suggesting that persons living alone, persons living in one-room housing units, and new arrivals in a residential area are all at high risk of being relatively isolated from their neighbors and that such isolation can have, as one of its consequences, the development of that kind of psychopathology which results in identification as a patient and subsequent hospitalization.

Even though persons not living in family units may be more socially isolated than other persons, they represent a heterogeneous population that can be subdivided into age, sex and marital status aggregates with different responses to living outside a residential family unit. Thus, the responses of young, never married males who are students or recent entries into the labor force can be

expected to be different from those of older widowed males. In the former group, suicide rates will be high while in the latter group, rates of 'brain' syndromes will be high.

Marital Status

Research results indicate higher mental illness incidence for persons never married and for divorced, separated, or widowed, when compared with those married (Warheit, et. al., 1968-74; Dohrenwend and Dohrenwend, 1974; Sorkin, et. al., 1973; Froland, 1975; Pollack, 1975). How much greater incidence is generally not indicated.

Divorced and separated persons tend to have higher levels of serious mental disorders than married persons (Bachrach, 1975). In fact, it has been suggested that "the single most powerful prediction of stress-related physical as well as emotional illness is marital disruption (death of a spouse, divorce or separation) (Bloom, 1975: 298). One reason appears to be the fact that the cultural system of the United States rewards adult persons for being married. Marriage is an appropriate part of the successful performance of an adult role. Within marriage, women have higher levels of mental disorder than men. This may be linked to the fact that "low status, undemanding position of the housewife is not consonant with the educational and intellectual attainment of a large number of married women and is therefore frustrating" (Warheit, 1974). The confinement of women in the home may be a contributing factor. In some studies, but not all, single persons, especially men, have higher levels of mental disorders, particularly serious disorders such as schizophrenia, than married persons (Brown and Birley, 1968). The rationale provided is that "the prevalence of mental disorder is high among never-married relative to married because persons with mental disorders are less likely ever to have married than are mentally well persons (Bachrach, 1975). For mild

disorders, single women may have lower levels of disorder than married women (Warheit, 1975).

It should be noted that most studies comparing marital status and mental illness fail to control for age. This omission may significantly confound the results of a study. For example, there are at least two different types of never-married persons --younger persons for whom the likelihood of marriage is moderately high and older persons for whom the likelihood of marriage is low. Because marriage is normative in our society, it may be expected that mental illness will be higher for never-married persons with reduced likelihood of marriage than for currently married persons.

Widows and widowers can be expected to have higher levels of mental illness than married persons. In part, this may reflect the stress and readjustment required with the death of a spouse. In the Holmes and Rahe Scale of Stressful Life Events, death of a spouse is consistently the most stressful undesirable event.

Residential Mobility and Community Instability

High rates of geographic mobility indicate community instability in structure and probably somewhat in culture. On the other hand, low or moderate mobility indicates a relatively stable social structure and more homogeneous community culture relative to other communities with the same degree of rural-urban characteristics.

It has been observed that the "large-scale movement of people is usually indicative of major social change or of a major social problem" (Bogue, et. al., 1957 1). More specifically, with respect to mental health, it has been suggested that geographically mobile persons, particularly migrants, have higher levels of schizophrenia and mental disability in general. The rationale for this position is that geographical mobility is apt to be stressful because it involves the disruption of concrete social relationships in one community or neighborhood and the effort to re-establish such social relationships in another perhaps culturally different community or neighborhood. The

'culture shock' of entering a new and different environment as well as the absence of established and effective social support networks in the new community or neighborhood are believed to increase the probability of serious mental disability. Moreover, mobility is a recognized stress factor regardless of whether it represents an improvement in circumstances as a part of the process. For many reasons it is a greater stress-inducing experience for those in low than those in moderate and high scoioeconomic status (Warheit, et. al., 1968-74; Froland, 1975).

Mobility is also less stressful for intact than broken families and less for those with stable status than for those who are socially upwardly mobile as well as geographically mobile. Therefore the value of mobility as an indicator of stress and mental illness incidence must be considered as an interrelated multiple rather than a single variable factor. To our knowledge, no significant research on mobility and incidence, with controls on relevant socioeconomic and social mobility variables, has been done.

The existing empirical research does not consistently support the position that residentially mobile persons have higher levels of mental disability. This is because the position stated above is incomplete. A more reasonable position about the anticipated consequences of residential mobility is presented below.

> Residential mobility involves the changing of concrete social relationships and accordingly may be associated with immediate or potential gratification or deprivation. Any change or modification of an actor's social position may be viewed at the time of the change as potentially costly, involving deprivation. A change may be viewed as personally costly to the extent that a change involves the disruption or modification of satisfying relationships for which no substitutions of an equally valued relationship is possible and/or for which no institutionalized mechanisms for counteracting or adjusting to the change exist. The extent to which no change in an actor's position involves the maintenance of unsatisfactory relationships and extensive negative sanctions, lack of a change may be personally costly. Thus to the extent that migrants identify with the style of life and value orientations of the communities of origin and are committed to their particularistic relationships in such communities, migration is an

essentially painful process. Beegle states this proposition as follows:

> The identification and cohesiveness resulting from interaction with groups as well as patterned relations through time, nourish residential stability. These ties and cohesiveness form the basis of satisfactions. Through migration, group ties and probably at least some patterned relationships, are severed, at considerable social cost to the migrant. In such cases migration is viewed as an essentially painful, socially costly process.

On the other hand, to the extent that migrants fail to identify with the community of origin, accept alternative styles of life and value orientations, and are not committed to particularistic relations in their primary interaction systems, migration may be less costly and perhaps a source of immediate or potential gratification (Goldsmith, 1961).

Residential Life Style: Type and Condition of Dwelling Units

It has been suggested that type, condition and control of dwelling units has significant effects upon behavior. Effects, which are not completely accounted for by other factors, we shall refer to as residential life style. Residential life style denotes the day-to-day activities conducted in and around a type of dwelling unit. We will discuss type of housing first. However, we wish to emphasize that since quality of housing varies widely, no generalizations are likely to be meaningful, except when used in combination with other variables such as condition of housing, density of occupancy, proportion in poverty and socio-economic status.

Type of Housing. Numerous authors have suggested that there are distinguishable life styles associated with residence in rented apartment and owned single dwelling units both at the household and area levels of analysis. In fact, Beshers (1962) argues that a crucial contrast in modern industrial society is between "apartment-house mode of life and separate-home modes of life." Abu-Lughod (1969: 209), for example, refers to "high differentiation of residential subareas by house type as one of the defining conditions of urban organization, particularly in the "terminal

stage of the demographic transition." Greer (1963) also indicates it is not the type of dwelling units, as such, that gives rise to the life style identified with single dwelling units or apartment living, but the interaction of type of dwelling unit with socioeconomic status, family status and family life cycle. He asserts that each type of housing has associated with it a distinctive population characterized by a particular style of life. In apartment houses, particularly when economic status is sufficient to allow a residential choice, one finds childless families--both young and old and single adults. Married, as well as single women of such areas, tend to be employed. Greer maintains that in the said populations residents develop little sense of community attachment or involvement since there are few activities which focus on the dwelling unit. Hence, these areas do not serve as a site for formal and informal participation. In our view, the above position needs to be modified to recognize that some informal interaction and casual visiting may occur in a middle rank as well as poor apartment houses. In the middle rank apartment house, we contend that the community sandbox, swimming pool, game room and laundry room, are potential sites for two-way interaction that can easily lead to the emergence of primary-like groups. Given the occasion for interaction, to the extent that apartment house populations are stable and homogeneous, one can anticipate primary-like groups. Gans emphasized that even in apartment houses, when population selectivity results in homogeneity social interaction may increase. Thus, he states "one need only contrast the apartment house located in a transient heterogeneous neighborhood and exactly the same structure in a neighborhood occupied by a single ethnic group. The former is a lovely, anonymous building, the latter a bustling microsociety" (Gans, 1968: 43).

In the single dwelling area, one finds families with children, high rates of home ownership and low rates of employment of women. The preference for and residence in single dwelling units can be found not only in the middle and upper economic status groups but in the lower economic status populations as well.

The importance of single dwelling units may be most crucial to the lower middle class, given the importance of establishing a comfortable, supporting, and home-centered family with children which maintains some informal interaction with neighboring adults and children.

Condition and Density of Housing. Condition of housing is generally highly correlated with the socioeconomic status of residents. Overcrowded housing and particularly highly overcrowded housing is highly correlated with populations in poverty. High density occupancy makes household management and effective and satisfying family interaction patterns difficult at best. Such conditions probably increase the social and psychological stress, and thus it is expected, would be related to a higher incidence of mental illness for those involved. Inadequate housing frequently accompanies low socioeconomic status. When present it can perhaps be an additional stress factor which assures that incidence will be higher. This factor should therefore be included in multiple indices of need for mental health services.

Thus it appears that overcrowded and poor housing tend to disrupt effective status-role performance. The net result of disrupted status-role relationships is an increase in social stress, particuarly among the more susceptible (Greenbie, 1974). Some attribute the disruptive effects to the fact of overcrowding as such. In part, this position has been supported by animal studies such as those of Calhoun with Norwegian rats. "Calhoun linked... crowded conditions...to pathological behavior...the neglect of maternal duties, hyper- and homosexuality, and the withdrawal of individual animals from social interaction." (Stokols, 1972: 73). This position also has been supported by observation of human subjects. Some of the consequences of overcrowding within the household and its concomitant lack of privacy are "mental strain arising from constantly having to 'get along' with other people" (Schorr, 1963: 13), competition among siblings and relatives for "care and desired responses," and a lack of "regularity and order essential for adequate socialization" (Bernard,

1966: 131-133). Each of these increases the probability of mental disability.

While some contend that the disruptive effects are a result of cultural expectations, such as the right to a room or to have unobserved sexual relations (Greenbie, 1974), still others attribute higher levels of mental disability in areas with high concentrations of overcrowded and poor housing to the intervening variable, social disorganization. This argument may be summarized as follows:

1) Increased crowding within the household and accompanying poor housing conditions increases the amount of activity within and outside the residence.
2) Increased activity results in increased social differentiation (thus increasing the need for effective communication) and decreased social integration and solidarity within the households.
3) If effective support systems exist outside the household, then social disorganization need not occur. If effective support systems do not exist, then social disorganization will occur.
4) When social disorganization increases, mental disability increases (see Rosen, Goldsmith and Redick, 1976).

Activities outside the household, such as street activities of lower status populations, can, but do not necessarily, provide an effective social support system for all residential populations. Thus, the existence of areas of overcrowded and poorly housed people is an alert to the investigator that social disorganization may exist.

In conclusion then, we suggest, for all of the above reasons, that poor housing and overcrowded conditions are associated with higher levels of mental disability.

Other Populations with High Potential Need for Health, Welfare and Other Services

The variables in this sector are particularly potent as indices of need for mental illness services as well as other services. This is true in part because a number of them combine two or more factors with research evidence of relatedness to mental illness as reported above. For example, aged persons living alone, aged persons in poverty, extremely crowded housing without complete plumbing facilities, Negro female headed households with own children, large households with low income, female headed families with children in poverty, disabled persons in and out of institutions and unable to work, working mothers of preschool children and working mothers of children under 18.

IMPLICATIONS

This review of empirical evidence regarding variations in mental illness according to sociodemographic and epidemiologic characteristics of a population provides a basis for inferring need for various mental health services. Numerous other questions are raised by the preceding discussion. Does the relative importance of sociodemographic variables vary from community to community? If so, what community factors cause this? Does the heterogeneity or homogeniety of a community in terms of socioeconomic status or ethnic composition make a difference? Are sex ratios, residential mobility and community integration relevant factors? How do community mental health needs change in the face of disasters, recessions and other major social changes? Are certain social conditions associated with certain types of mental illness? How does the geographic location of services influence utilization? None of these questions can be answered separately. What is needed is a total picture of the mix of sociodemographic factors, social conditions and life events which creates high risk populations.

A distinction should be made between "need"--the services people are assumed to require, by some criterion of what constitutes mental health--and "demand"--the services people want. While it may be idealistic and financially impossible to plan community mental health services to meet all of a population's needs, some compromise between "demand" and "need" seems desirable (Boulding, 1967).

A compromise is difficult to reach, however, because of the lack of consensus on the criteria of mental health and mental illness. Perhaps techniques such as a modified Delbecq and Van de Ven (1971) approach might facilitate arriving at a consensus. A second requirement is for additional data measuring incidence of mental health and illness along with the factors which are thought to predict high risk status. Hagnell's (1966) modest investigation has demonstrated one way to do such studies. It might be that such data could be collected through ongoing research efforts, such as the National Health Survey.

While we await more definitive answers, it seems doubtful that we should continue to compute estimates of need as though the rates are equivalent from one area to another when they are quite different on sociodemographic characteristics. It seems more reasonable to begin to make judgments about how much greater the risk of mental illness is for some groups, compared with others. As judgments are made about how much greater the risk of mental illness is for some groups, compared with others, it will be necessary to remember that different disorders are not randomly distributed throughout the population. Estimates are needed of the prevalence of different types of mental disorders and their relationship to sociodemographic variables. Estimates are needed of the prevalence of "at risk" groups as well as "ambulatory" groups.

It may also be possible to estimate differential rates for various areas by means of a multiple regression analysis of the risk factors with utilization rates, but controls need to be placed on availability of resources

to meet need indicated by the risk factors and on whether population groups have private or public resources to gain access for utilization (Garrison, 1973). Otherwise, such analyses should be interpreted with extreme caution. The underutilization of health services by some needy groups could yield extremely misleading results.

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